		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155333	B. WIN			03/04/2	011
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LONGEST ST		
PAOLI H	EALTH AND LIVING	COMMUNITY INC					
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F0000	This visit was for State Licensure So This visit was in a Investigation of Convestigation of Converted Provider number: AIM number: Survey Team: Debora Barth, RN Brenda Buroker, In Donna Downs, RN Consus Bed Type SNF: 13 SNF/NF: Total: 100 Census Payor Type Medicare: 18 Medicaid: 72 Other: 10 Total: 100 Stage 2 Sample: Supplemental Sam These deficiencies	a Recertification and urvey. conjunction with complaint IN00086411. March 1 - 4, 2011 000226 155333 00267730 I, TC RN N : 87 nple: 3 s also reflect state	F00	00	This plan of correction is to se as Paoli Health and Living Community's credible allegatic of compliance. Submission of the plan of correction does not constitute an admission by Pathealth and Living Community it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provious of nursing care and other services in this facility. Nor do this submission constitute an agreement or admission of the survey allegations.	on his oli or t e sion	
LABORATOI	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	iNATURI	-(TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JWWC11 Facility ID:

000226

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011	
		100000	B. WIN			03/04/2	011
NAME OF	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE LONGEST ST		
	EALTH AND LIVING			1	IN47454		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
5.50	findings in accordance with 410 IAC 16.2.		1				
	Quality review 3/10/11 by Suzanne Williams, RN						
F0164 SS=D	facility failed to president who recent treatment in the tof 3 residents who pressure ulcers. Findings include 1. During obserulcer care on 30 the therapy rook care to Resider was lying on he receiving diather therapy to increarea). The therapy to increarea). The therapy room and residents receiving diather therapy to increare behind a confect of the other activity in the open room. The care behind a confect of the otheractivity in the open room. The resident critical treatment. Following the room, but the resident had president had presid	vation of pressure /3/11 at 9:43 A.M., in m, PT #1 provided ht #113. The resident er left side and was ermy (deep heat ease circulation to an rapy room was a large, there were five ving treatment in the e resident received cloth curtain within 4 r residents. The pen room could easily ied out in pain during owing the treatment, PT #1 indicated the eviously been treated	F01	64	F164 483.10, 483.75PERSON PRIVACY/CONFIDENTIALITY OF RECORDSI. The resident is now receiving wound care in homom. II. All residents receiving therapy for wound care will have dressing changes completed in their rooms. III. The systemic change is that all residents receiving therapy for wound care will have dressing changes completed in their rooms. All therapists will receive education personal privacy. IV. The therapy supervisor will observe minimum of two dressing changes provided by therapy weekly for 4 weeks to monitor that privacy is provided to the resident. The audit will then continue at 2 dressing changes monthly for 11 months. The therapy supervisor will monitor all residents receiving dressing changes by therapy to determit that they are receiving dressing changes in their room. Any identified concerns will be addressed immediately. The results of these reviews will be discussed at the monthly facility Quality Assurance Comittee Meeting and frequency and duration of reviews will be adjusted as needed.	s er ve n are on e a s	04/03/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155333	B. WING		03/04/2011	
NAME OF I	PROVIDER OR SUPPLIE	D.	STREET	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	-ROVIDER OR SUFFLIE	K.	559 W	LONGEST ST		
PAOLI H	EALTH AND LIVIN	G COMMUNITY INC	PAOLI	, IN47454		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC I)	DATE	
	previous day.					
	2 1 2(0)					
	3.1-3(0)					
	3.3-3(p)(2)					
			1			
	L		1	1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155333	B. WING			03/04/2	011
	n o v v n n o v v n n v v n n				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			559 W	LONGEST ST		
	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F00	TAG			DATE
F0226		views and record	F02	26	F 226 483.13 (c)DEVELOP/IMPLEMENT		04/03/2011
SS=C		lity failed to develop			ABUSE/NEGLECT, ETC.		
	and implement abuse policy and				POLICIESI.The abuse policy h	nas	
	•	nclude reporting of			been updated to reflect notifyir	-	
	•	violations immediately			the Administrator immediately		
		rator. This had the			all allegations of abuse. This		
	potential to affe				presented to the surveyors due the survey process.II.All	ıırıy	
	residents in the	e facility.			allegations of abuse for the las	st	
					90 days have been reviewed a		
	Findings includ	e:			the Administrator was		
					immediately notified in all		
	The abuse police	cy and procedure was			cases.III.The systemic change		
	•	he Administrator on			that the policy has been updat to reflect that the Administrato		
	3/2/11 at 3:40 g	o.m. A review of this			will be immediately notified of		
	policy indicated				allegations of abuse. All staff		
	"Section IV. Ide	_			be offered education on the		
		gns And Symptoms Of			updated policy. All newly hired	b	
		tatement. Our facility			staff will offered education		
	-	e any form of resident			utilizing the new abuse policy upon hire.IV.The facility		
		ct. To aid in abuse			Administrator will conduct rand	dom	
	_	personnel are to report			interviews with staff in regards		
	any signs and	·			the abuse policy. This will occ	ur	
					with a minimum of 10 staff		
	_	to their supervisor or to			members weekly for 4 weeks a		
		nursing services			then proceed to 10 staff members monthly for 11 months. The	pers	
	•	Section V. Abuse			results of this audit will be		
		Policy Statement. All			discussed at the monthly facili	ty	
	•	ent abuse, neglect and			Quality Assurance Review		
	-	nknown source shall			meeting and the frequency and	d	
	be promptly an	•			duration of the reviews will be adjusted as needed.		
	• •	facility management.			aujusieu as needed.		
		eporting Abuse To: A.					
	Facility Manage	•					
		the responsibility of					
	our employees	, facility consultants,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/04/2011		
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	(ONGEST ST		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC		PAOLI,	IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	attending phys		+	TAG	DEFICIENCY)		DATE
	0.,	ors etc., to promptly					
		dent or suspected					
	•	lect or resident abuse,					
	including injuries of an unknown						
	source, and the	eft or misappropriation					
	of resident proj	perty to facility					
	management."						
	During an inter	view with LPN #1 on					
	_	p.m., she indicated for					
		abuse she, would report					
	_	Director of Nursing					
	Services). On	3/4/11 at 6 a.m., during					
	an interview wi	th LPN #2, she					
		ported allegations of					
		uld report to the DNS.					
	_	view with LPN #3 on					
	·	p.m., she indicated for					
	to the DNS.	abuse, she would report					
	to the DNO.						
	3.1-28(a)						
	, ,						

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING		COMPL	ETED
		155333	A. BUII B. WIN			03/04/2	011
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LONGEST ST		
PAOLI HI	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0241	Based on obse	rvation and interview,	F0241		F 241 483.15 (a)DIGNITY AND		04/03/2011
SS=E	the facility failed to ensure residents				RESPECT OF INDIVIDUALITYI.All residents		
-	were treated wi	ith dignity related to			who expressed concerns with		
	meals served p	romptly to ensure			their meal quality have been		
	temperatures o	f hot foods were			interviewed regarding their		
	•	en served. This			concerns and currently expres	s	
		residents, who met			no issues with the temperature		
	the criteria as in				of meal service. Residents #1	7,	
		cerns for food quality			#83, #32 and #61 were		
	•	ident #24, #42, #29,			individually assessed to determine their needs. Dining		
	•				services have been adjusted to		
		8, #165, and #6). This			provided warm, prompt meal		
	also affected 4				service with assistance as		
		g the noon meal during			needed. Individual interviews		
		ions of room tray			reflect that the residents are		
	service on 1 of	5 units (100 Unit) of			receiving meals at temperature	es	
	the facility. (Re	esidents #61, #83, #17,			that are satisfactory to		
	and #32).				them.II.Other residents were reviewed either through intervi	iow	
					or observation to determine	EW	
	Findings inclu	de:			satisfaction with meal service.		
					Any resident with concerns wa	as	
	1 Posidont #2	24 was interviewed			assessed for appropriate meal	I	
	on 3/1/11 at 11				service and location of receiving	•	
					meals. Dining service and sta	ff	
		ated she takes her			assignment were adjusted to	mio	
		oom and the food is			meet their needs.III.The system change is the dining service an		
	sometimes ser	rved cold.			staff assignment have been	iu	
					adjusted to meet the residents	;	
	2. Resident #4	2 was interviewed			needs in regards to meal servi		
	on 3/1/11 at 11	:34 a.m. She			Staff has been provided		
	indicated the f	ood is served cold.			education regarding new		
					assignments to facilitate dining	g.	
	3 Resident #2	9 was interviewed			The facility is encouraging all residents to go to the dining ro	om	
	3. Resident #29 was interviewed				for meals and providing	JUIII	
	on 3/1/11 at 11:40 a.m. She indicated the food served on room				assistance to those residents	who	
					eat in their rooms through nurs		
	trays is not se	rved at the proper			_		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155333	B. WIN			03/04/2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			559 W I	LONGEST ST	
		G COMMUNITY INC			IN47454	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
1710		ndicating the food is		1710	supervision and prompt dining	
	served cold.	idioding the rood is			services.IV.The Director of	
	4. Resident #35 was interviewed			Nursing or her designee will au		•
					meal service and dignity relate to meals by random observation	
	on 3/1/11 at 11				of meals on each shift. These	• • • • • • • • • • • • • • • • • • •
		ood is served cold			audits will occur a minimum of	3
		resident indicated			times weekly for 4 weeks and	.f 4
		and sausage are			then 1 time weekly for a total of months, proceeding to 1 time)I 4
		oast is cold and			monthly for a total of 12 month	ıs.
	"hard as a roc	k."			The Certified Dietary Manager	• • • • • • • • • • • • • • • • • • •
					her designee will conduct rand audits of food temperatures wi	
	5. Resident #162 was interviewed				meal service 3 times weekly for	
	on 3/1/11 at 2:3	36 p.m. The resident			weeks, and then 1 time weekly	•
	indicated the f	ood is served cooler			a total of 4 months, proceeding	-
	than she desir	es.			1 time monthly for a total of 12 months. The results will be	
					discussed in the facility month	ly
	6. Resident #1	58 was interviewed			Quality Assurance meeting an	d
	on 3/1/11 at 3:3	30 p.m. He indicated			the frequency and duration wil	l be
	the food is usu	ually served cold and			adjusted as needed.	
	the staff will he	eat it, if asked to.				
	7. Resident #1	65 was interviewed				
	on 3/2/11 at 8:3					
		ood was not warm				
	when served, a	and "eggs should be				
	warm."					
		was interviewed on				
		a.m. The resident				
		t of the food is cold,				
		nt indicated staff will				
		holler about it - just				
	eat."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN47454				
(X4) ID PREFIX TAG	9. On 3/1/11 at 11:52 a.m., the meal service was observed on the 100 unit. Resident #17 and #32 were observed with their meals, uncovered, in front of them on overbed tables, while they dozed in their chairs. Resident #61		ID PREF	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	was in bed, sle uncovered, on front of her at tl p.m., Resident her bed, with h	eping, with her meal, the overbed table in his time. At 12:05 #83 was observed in er meal, uncovered, on ble in front of her while					
	observed eatin Resident #17 re chair, with her untouched in fr p.m., Residents continued to do front of them, winteraction/cuel Resident #17 re staff to eat her Resident #61 a encouragement which had been front of them, so 12:05 p.m.	at 12:16 p.m., Resident #32 was observed eating her meal while Resident #17 remained dozing in the shair, with her uncovered tray ontouched in front of her. At 12:23 p.m., Residents #61, #83, and #17 continued to doze with their meals in ront of them, without staff interaction/cueing. At 12:30 p.m., Resident #17 received cueing from taff to eat her meal. At 12:40 p.m., Resident #61 and #83 received encouragement to eat their meals, which had been sitting, uncovered in ront of them, since 11:52 a.m. and 2:05 p.m.					
		service in the dietary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155333	A. BUILDING		03/04/2011
			B. WINGSTREET .	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			LONGEST ST	
		G COMMUNITY INC		IN47454	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
		e Dietary Manager	1111		
	•	were 56 residents who			
	took their meals	s in their rooms.			
	11. On 3/3/11	at 11:22 a.m., the			
		ed on the 100 unit.			
		e observed to serve			
	•	e cart. Resident #61			
	was served at				
		bed, and her tray was			
		bed table in front of			
		od uncovered. The ed to dozing as soon			
		the room. Resident			
		d at 11:40 a.m. The			
		o in a wheelchair, and			
		et up in front of her on			
	•	le. The food was			
	uncovered, and	staff left the room.			
	The resident di	d not make an attempt			
	to eat any of th	e food on the tray in			
		no staff were present			
	to encourage th	ne resident to eat.			
	Δt 11:47 a.m. t	two CNAs, one of			
	=	serving the 100 unit,			
		the trays from the 300			
	•	CNA from the 100 unit			
		e 100 hall trays were			
		was helping on the 300			
		CNA on the 100 unit to			
	assist residents	s taking their meals in			
	their room.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011	
		100000	B. WING	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER			LONGEST ST	-		
		G COMMUNITY INC		IN47454			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		(X5)	
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE	
	At 11:58 a.m.,	Residents #61 and #83					
		anged; their trays were					
	open in front of	them while they dozed					
		chair. At this time, the					
		100 unit that went to					
		00 unit, went back to					
		"check with her" CNA on the hall) and					
	, ,	e would go to the dining					
		The CNA left 100 hall					
	at 12:01 p.m. to	assist in the main					
		t 12:05 p.m., Resident					
		sleeping with her tray,					
		ont of her and no staff					
		esident #83 was awake					
		her tray in front of her table, but she was not					
		staff were providing					
	assistance/enc						
		-					
	3.1-3(t)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC		COMPLETED	
		155333	B. WIN			03/04/2011	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LONGEST ST		
DAOLLHI		G COMMUNITY INC			IN47454		
	LALITI AND LIVING	3 COMMONTT INC		i AOLi,			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	DEFICIENCY)		DATE
F0248	Based on observation, interview and		F02	48	F 248 483.15 (f)(1)ACTVITIES		04/03/2011
SS=D	record review, t	the facility failed to			MEET INTERESTS/NEEDS O		
	provide activitie	es to meet the			EACH RESIDENTI.Resident # was interviewed and has an	.03	
	resident's intere	ests for 1 of 3 residents			updated Activities Care Plan th	nat	
	reviewed for ac	tivities in a sample of			meets the criteria for structure		
		teria for structured			activities of the cognitively		
		e cognitively impaired.			impaired.II.Cognitively impaire	d	
	[Resident #63]	ooginavery impaned.			residents activities programmi	٠ .	
	[IXESIDELII #03]				has been reviewed for structur	red	
	Cinalinana in alced				activities for the cognitively		
	Findings includ	e:			impaired. Their Activities Care Plan has been updated and		
					reflects the resident's		
	During observa	tions on 3/3/11 at 8:18			interests.III.The systemic char	nge	
	A.M. and 10:45	A.M., Resident #63			the Activities Director is attended	- 1	
	was lying in bed	d in her room.			stand down meeting 5 times	Ĭ	
					weekly to be updated on		
	On 3/3/11 at 1:	30 P.M., the resident			residents who have changes a	ind	
		sitting on the side of			may need changes to their		
		d a visitor talking to			activities programming. The	_	
	her.	d d violitor talking to			facility is updating all resident's activity programming with each		
	nei.				MDS to reflect the resident's	'	
	The eliciast seri	and of Davidont 400			interests, as well as providing		
		ord of Resident #63			structured activities for the		
		on 3/3/11 at 2:40 P.M.			cognitively impaired. The		
		Minimum Data Set			Activities Director has been		
	_ =	nent for a significant			offered education in this		
	change on 12/2	29/10. The			programming and		
	assessment ind	dicated an interview			implementation.IV.The	,,,,,,,	
	with the resider	nt for activity			Administrator or her designee monitor the structured	vvIII	
	preferences:	-			programming for a minimum o	_f	
	•	is it to you to keep up			10 residents weekly through		
	•	do things with groups			observation and interview of th	ne	
	of people, do your favorite activities,				staff caring for them for 8 weel	ks	
	and participate in religious services or practices? The resident indicated				to evaluate if the resident's		
					interests and needs are being	_	
					met. This audit will then occur		
	these things we	ere somewnat			minimum of 10 residents mont	illy	
l			1		1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		155333	B. WIN			03/04/20	011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ		
NAME OF F	PROVIDER OR SUPPLIER			1				
DAOLLU		G COMMUNITY INC		1	LONGEST ST			
PAULITI	EALTH AND LIVING	3 COMMONTE INC		FAOLI,	IN47454			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	important to he	r.			for a total of 12 months.The			
	The MDS indicated the resident was				results will be discussed in the			
	totally depende	ent on staff for			facility monthly Quality Assura Committee meeting and the	nce		
	locomotion off t				frequency and duration will be			
					adjusted as needed.			
	 Interview with t	he Activity Director						
	Interview with the Activity Director [AD] on 3/4/11 at 9:12 AM., indicated							
		d some cognition						
		•						
	•	AD indicated there						
	-	plan for activities which						
	was individualiz	zed.						
	Review of the 0	Care Plan, dated						
	2/16/11, indicat	ted:						
	"Resident invol	ved in activities some						
	of the time from	n 1/3 to 2/3 of time.						
		D.H. [hard of hearing].						
	Goal - Residen							
		h quality and quantity						
		r quality and quantity						
	of activities.							
	Interventions:							
		ctivities, and a daily						
	schedule that re							
	resident's prior	lifestyle.						
	Involve residen	t with those who have						
	shared interest	S.						
	Encourage resi	dent to become						
	•	ctivities such as music,						
		church, and socials.						
	-	nt's current abilities.						
	•							
	-	in which activities are						
	•	room, day room.						
		of upcoming activities						
	by providing ac	tivity calendar, verbal						

PRINTED: 03/25/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIEF	COMMUNITY INC	559 W	ADDRESS, CITY, STATE, ZIP COL LONGEST ST IN47454	DE .	
	SUMMARY S (EACH DEFICIEN REGULATORY OR reminders, end Review of the A indicated: On 12/28/10, "I pleasant and a wants to staff. meals and activitions often an supportive. Re independent ac materials as no activities. I will encourage to p activities. Resi changes in acti assessment da On 1/4/11, "Re changes since	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) OUR ACTIVITY Progress Notes Resident is alert and ble to voice needs and Resident is up daily for vities. Resident has and family is very esident prefers to do ctivities. Will provide eeded for independent also invite and articipate in group dent has had no vities since last	559 W	LONGEST ST	TION LD BE	(X5) COMPLETION DATE
	provide resider needed for inde Will invite and participate in g Interview with 0 9:30 A.M., indicated she that indicated she that a little down who will be seen a little down who will b	roup activities." CNA #1 on 3/4/11 at cated the resident has and has a niece who every day. The CNA hought the resident got nen the niece was away The CNA indicated she				

000226

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING		COMPL	
		155333	B. WING			03/04/2	011
NAME OF I	PROVIDER OR SUPPLIER	- {			DDRESS, CITY, STATE, ZIP CODE		
DAGLLI	EALTH AND LIVING		I .		LONGEST ST		
	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG				IAG	BH IOLINO 1		DATE
	group activities	s why she did not enjoy					
	group activities) .					
	Interview with the AD at 10:07 A.M.						
		cated she kept a record					
		es and provided the					
		calendar. The					
		ot attended any group					
		independent activity					
	,	February 2011					
		esident had visitors					
	daily and there	were no other					
	activities listed	as being done.					
	The Independe	ent Activity Tracking					
	Log indicated,	"Utilize this form for					
	residents who	do not engage in group					
	activities but ar	e highly involved in					
		ctivities. Place a check					
		ch heading that applies					
		e date." The AD					
		nad volunteers visit the					
		days, and offered					
	magazines to t	ne resident.					
	0 2/4/44 = 40	20 D.M. the					
	On 3/4/11 at 2:	•					
		ndicated the problem					
	and provided a	nad been addressed					
	· •	e on it, "enjoys flowers,					
		e on it, enjoys nowers, eading, and likes					
	having compar	_					
	i naving compar	iy & violiliy.					
	3.1-33(a)						
	(4)						
	•		-				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER	COMMUNITY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN47454		L		
	EALTH AND LIVING SUMMARY S' (EACH DEFICIEN REGULATORY OR Based on record the facility failed update care plassore treatment/ affected 1 of 3 with pressure some who met the crisores. This also supplemental some supplemental som	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) IN dreview and interview, In the sample of a steria for pressure or affected 1 of 3 ampled residents essure sores. #100) e: record of Resident #62 on 3/4/11 at 10:14 a.m. as admitted to the 6. The care plan for, in breakdown, dated ordated through ted the resident was RW" (up as desired	F02	STREET A 559 W I PAOLI, ID PREFIX TAG	LONGEST ST	SIVE 0 as so refree sto vill staff I ge in he	(X5) COMPLETION DATE 04/03/2011
	2/9/11, indicate "red 1 in (inch) buttock" when s hospital. A trea	d the resident had a circular area (R) (right) she returned from the atment order of Zinc ttocks was obtained at			updates regarding pressure so treatment and prevention 5 da a week at the daily stand up meeting for 12 months.The results will be discussed in the facility monthly Quality Assura	ys e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155333		A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011		
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	l	ET ADDRESS, CITY, STATE, ZIP CODE W LONGEST ST		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC	I	LI, IN47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	dated 2/9/11, in was non-weigh leg related to the plan for potential was not change readmission. On 2/11/11, Hy (pain medication resident as well the right foot to pain and edem pain medication given four time) On 2/18/11, at indicated) nurse resident had an (left) inner butter (less than) 0.1. missing. Area the of drainage. We periwound is pictured in the perimonal of the pe	admission assessment, indicated the resident at bearing on the right the fracture. The care all for skin breakdown and at the time of at the time of a drocodone 7.5/325 and a was ordered for the at as an ace wrap from a the thigh related to a. On 2/17/11, the an was ordered to be a daily routinely. 12:35 (no a.m. or p.m. are notes indicated the an "Area noted to (L) tock 1.7 x (by) 0.6 x < Full layer of skin as scant amt (amount) found bed red, and ink. [No] pain noted and is now staff for transfers, T & repositioning); and acture) of (R) femurate to multiple sides.		Committee meeting and the frequency and duration will be adjusted as needed.	e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		559 W	ADDRESS, CITY, STATE, ZIP COE LONGEST ST IN47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) UND Evaluation Flow	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	resident had a on the inner lef					
	for, "Resident h R/T (related to) ." Documentat plan of care wa	care plan was initiated has a pressure ulcer recent fx; immobility ion of change in the lacking until after the lacking a pressure area.				
	(Director of Number talked to the number readmission as Resident #62 refracture, and the area on her right	2:00 noon, the DoN rses) indicated she urse who completed the isessment when eturned, after the in e nurse indicated the int buttock resolved inc oxide was applied.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155333	B. WIN			03/04/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				LONGEST ST		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	DATE	
F0279	2. The clinical	record of Resident	F02	79	F279 483.20(d), 483.20(k)	04/03/2011	
SS=D	#100 was reviewed on 3/3/11 at 3				(1)DEVELOP COMPREHENS	I	
33-D	P.M. and indicated an				CARE PLANSI Residents #10	I	
		essment on 9/27/10.			has no pressure ulcers and ha	I	
		essure ulcer Resident			an updated care plan related t	0	
	•				pressure ulcer prevention. Resident #62 has updated car	e	
		otocol [RAP] which			plans related to pressure ulcer		
	indicated:	minto form managers			treatment and prevention.II.Th		
		risk for pressure ulcers			facility has updated the care		
		impaired mobility and			plans of all residents in regard	s to	
		She is up with 2 assist			pressure sore treatment and		
	T & R [turning a	and repositioning] per 2			prevention.III.The systemic	.:0	
	assist and use	of 1/2 SR's [one-half			change is that care planning was be completed by the nursing s		
	side rails]. Pres	ssure relieving			upon admission and with any	lali	
	_	d and cushion in w/c			significant change regarding		
		aily skin checks. Skin			pressure sore treatment and		
		ensive] assist of 2 for			prevention. In addition, the		
	toileting and pe	-			weekly interdisciplinary "At Ris	sk	
					Meeting" will include a review	of	
	ino pressure uit	cer on admission.			the care plans of new		
		01: 45:1			admissions, readmissions and	I	
	The Admission				residents with significant chan	ge	
		dicated on the 9/15/10			regarding pressure sore treatment and prevention.		
	· ·	e resident had the			Education was offered to the		
	potential for inc	rease in friction and			nursing staff on care planning	in	
	shearing.				regards to pressure sore		
					treatment and prevention.IV.T		
	The Weekly Wo	ound Evaluation			Unit Managers or designee wil		
	_	ed the resident was			audit the charts of all new		
		pected deep tissue			admissions, readmissions and		
	-	heels on 10/4/10.			those who have significant change for care plans and/or		
		110010 011 10/7/10.			updates regarding pressure so	ore	
	An avaluation -	on 10/6/10 indicated			treatment and prevention 5 da		
		on 10/6/10 indicated			a week at the daily stand up		
		e bilateral heels were			meeting for 12 months.The		
		lent digging her feet			results will be discussed in the		
	into the bed. A	n air mattress was			facility monthly Quality Assura	nce	

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155333	A. BUILDING B. WING		03/04/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
PAOLI H	EALTH AND LIVING	G COMMUNITY INC		LONGEST ST , IN47454	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	applied to the badded to the wa	ed and padding was /c pedals.		Committee meeting and the frequency and duration will be adjusted as needed.	
	A request for the development of was made on 3 Interview with Eplan provided with from the point of admission. Resindicated it was the problem, "Fibreakdown relabilat [bilateral] if [left] heel" was were handwritted on what date, to Float heels whith Enc [encourage bed] as much at x [treatment] at Vit C [vitamin Conforwound healing notify MD [med prn [as needed air mattress padded w/c percontinue foam of 30 days for professions."	the care plan prior to the fithe pressure ulcers 1/3/11 at 9 A.M. DoN indicated the care was for pressure ulcers of the resident's view of the care plan and undated and was for potential for skin ated to pressure areas neels." On 10/20/10 "I added. Interventions en, but it was unknown to include: le abed en res to get oob [out of as possible is ordered by et [and] Zinc sulfate ing ical doctor] and family and dals dressing to right heel x tection (area healed). Trovided by the DoN at 1/3/11 indicated on nurse et [and] CNA		1 ' '	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333			(X2) MU A. BUIL B. WINC	DING	NSTRUCTION	(X3) DATE COMPL 03/04/2	ETED
NAME OF F	PROVIDER OR SUPPLIER		p. wind	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC			LONGEST ST IN47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	[bilateral] heels bed, heels on b [with] 2.5 x 2.2 filled blister into red nonblanchi [two] dark spots	is. Resd [resident] in ped. Lt [left] heel c purple, dark red, fluid act. Rt [right] heel darking 2.6 x 3 mushy c s 0.1 x 0.1. Placed legs to get heels off					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/04/2011			
NAME OF F	PROVIDER OR SUPPLIER		p. (/ii.)	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		COMMUNITY INC			IN47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſE	(X5) COMPLETION DATE
F0309	Based on obse	rvation, interview and	F03		F309 483.25PROVIDE CARE/SERVICES FOR		04/03/2011
SS=D	ensure pain maprovided for 1 conformer pressure uld who met the critical for 3 residents who is pain recognition a stage 1 samp #29 and 74] Findings includ 1. During observation	of 3 residents reviewed ters in a sample of 3 teria for pressure ulcer dent #113], and for 2 who met the criteria for and management in alle of 20. [Residents] e: tion on 3/3/11 at 9 A.M.,			HIGHEST WELL BEINGI.Residents #113, #29 a #74 have updated pain assessments and pain management programs. In addition, the as needed pain medication is being documente per facility policy. II.The facility has updated all resident's pain assessments and pain management programs have been put into place where applicable. PRN pain medicat is being documented per facility policy.III.The systemic change includes that the 24 hour report	ed y ion cy	
	1. During observation on 3/3/11 at 9 A.M., Resident #113 was taken to therapy for treatment to a pressure area. The clinical record of Resident #113 was reviewed on 3/3/11 at 8:30 A.M., and indicated nurses notes dated 1/22/11 at 0230 [2:30 A.M.] "Res [resident] tearful when staff changes res q [every] 2 hours & repositions her or does any other care. Incont B & B [incontinent of bowel and bladder]. Found area on right buttock/hip area. Measures 5 CM [centimeter] x 5 CM reddened line, .5 cm width, 0 depth, & another 5 cm x 5 cm .5 cm width c [with] small scabs & reddened. Underneath the area is hard, approx [approximately]. 7 cm x 9 cm rounded. Res claims no pain. No distress s/s [signs or symptoms] observed." There was a physician's order dated 3/2/11, which indicated "PT [physical therapy] treatment. Sharp debridement as needed to R [right] hip. Dressing change clean c [with]				sheets and all new medication orders will be reviewed in the daily (5 days a week) clinical meeting by the interdisciplinary team. The chart of any reside with new complaints of pain, change in pain or new pain medication orders will be reviewed for an appropriate paassessment, pain management program and documentation of administration of pain medications. Nurses will be provided education on this systemic change, as well as paassessment and management.IV.The Director of Nursing or her designee will monitor a minimum of 10 prn palow sheets for non-medicinal intervention prior to and after medication administration week	y nt iin of ain	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING		COMPLETED	
		155333	B. WIN			03/04/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	LONGEST ST		
DAOLLH		G COMMUNITY INC		1	IN47454		
	LALIII AND LIVIN	3 COMMONTT INC		<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		acking wound c [with] wet			for 4 weeks. The audit will	4.0	
	gauze. Then secu	red c hydrochloride."		then proceed to a minimum of 10		10	
	A mbusisismis and	and dated 0/40/44 indicated			flow sheets monthly for an		
		er dated 2/16/11, indicated			additional 11 months. The Director of Nursing or her		
	"PT to eval et [evaluate and] treat unstageable wound to R [right] hip."				designee will review the pain		
					assessments and pain		
	The 2/16/11 PT e	valuation indicated, "will be			management programs for at		
		mes a week] for wound care			least 5 residents with new or		
		reatment] diathermy x 20			increased pain weekly for 4		
		lean - wound cleanser			weeks and then 5 residents		
	-apply santyl ointr	nent, then hydrocolloid."			monthly for 11 months to mon	itor	
					effectiveness. The Therapy		
	Observation of care on 3/3/11 at 9:43 A.M.,				Supervisor will monitor a		
		ad the diathermy (deep heat			minimum of 2 dressing change		
		e circulation to an area) in			provided by therapy weekly fo		
	1 '	ent's right ischial pressure			weeks then 2 dressing change		
		It was lying on her left side. cm diameter and 1 cm			per month for a total of 12 mon to observe for any pain issues		
		as redness surrounding the			to observe for any pain issues	•	
	1	out 5 cm in diameter.					
	Would exterially	out o om m diameter.					
	PT #1 indicated th	ne wound had just had					
		this week following the					
	debridement.						
		l out in pain during the					
		er the wound was touched					
	by the therapist.						
	Interview with DT	#1 following the treatment					
		not packed the wound with					
		because it had caused so					
	•	resident the previous day.					
		and provided day.					
	Interview with the	charge nurse caring for the					
		on 3/3/11 at 10:15 A.M.					
	indicated the resid						
	pre-medicated prior to the treatment. She						
		ce the resident came to the					
	facility a year ago	, she had cried all the time					

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
THEFTERN	or connection	155333	A. BUILDING B. WING		03/04/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER		559 W	LONGEST ST	
PAOLI HI	EALTH AND LIVING	G COMMUNITY INC	PAOLI,	IN47454	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
1710		in. "Even before we	1710		DATE
	touched her, she o	cried." LPN #1 was told the			
		in pain during the treatment did not follow the doctor's			
		the wound because the			
	resident was in pain.				
Interview with the DoN on 3/3/11 at 2:20 P.M.					
	·	gave the resident the prn			
		in, waited an hour, then ment with the wet gauze as			
	ordered.				
		ated the resident had			
	•	d pain before the yesterday. That was			
		ot pre-medicated, but			
	, ,	rder added to medicate			
		or to pressure ulcer			
	treatment today	/ .			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155333	B. WIN		03/04/2011		
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l	LONGEST ST		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ļ	TAG	DEFICIENCY)		DATE
F0309	2. The clinical record of Resident #29		F03	09	F309 483.25PROVIDE		04/03/2011
SS=D	was reviewed on 3/3/11 at 9:55 a.m.				CARE/SERVICES FOR		
	The resident's	diagnoses included,			HIGHEST WELL BEINGI.Residents #113, #29 a	and	
	but were not lin	nited to, chronic pain,			#74 have updated pain		
	general debility	•			assessments and pain		
	•	nd acute left arm			management programs. In		
	weakness.				addition, the as needed pain		
	weakiness.				medication is being document		
	The physician's	recapitulation of			per facility policy. II.The facilit	, I	
		·			has updated all resident's pain		
	_	on 2/24/11, included,			assessments and pain management programs have		
	but were not limited to, the following:				been put into place where		
					applicable. PRN pain medicat	ion	
	Tylenol Extra S	• "			is being documented per facili		
	medication) 500	0 mg (milligrams) -			policy.III.The systemic change		
	Take 1 tablet p	o (by mouth) Bid (twice			includes that the 24 hour repo		
	daily)				sheets and all new medication		
	Ultram (pain me	edication) 50 mg 1 po			orders will be reviewed in the		
	bid routinely				daily (5 days a week) clinical meeting by the interdisciplinary	,	
	Additional PRN	(as needed) orders			team. The chart of any reside		
	included:	,			with new complaints of pain,		
		g - Take 2 tabs (650			change in pain or new pain		
		y) 4 hrs as needed for			medication orders will be		
	pain or elevated	• •			reviewed for an appropriate pa		
	•	Take 1 tab po q 6 hrs			assessment, pain managemer		
	•				program and documentation o administration of pain	^r	
	as needed for p	Jaili			medications. Nurses will be		
					provided education on this		
	•	s progress note, dated			systemic change, as well as pa	ain	
		ted the resident had a			assessment and		
		r x-ray which showed			management.IV.The Director	of	
	,	oint disease. Nurses			Nursing or her designee will		
	notes indicated	the resident had the			monitor a minimum of 10 prn p flow sheets for non-medicinal	oain	
	x-ray completed	d related to complaints			intervention prior to and pain		
	of pain in her shoulder on 2/15/11 at				assessment prior to and after		
	1:00 p.m.				medication administration wee	kly	
						·	
					!		

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING			COMPLETED	
		155333	B. WIN			03/04/20	011	
			D. WIIV	STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIER	1		1	LONGEST ST			
DAOLLH		G COMMUNITY INC			IN47454			
	LACITI AND LIVING	3 COMMONTT INC						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	A physician's p 9/9/10, indicate back pain which arthritic in natural progress note of the resident co- pain with osteon The note indicate received 80 mg injection) in the The care plan, the resident hat pain related to general debility with a goal for the pain assessment daily pain rating administration in included the fold Monitor and received the pain: location, quality, alleviate factors. Use pain relief relaxation, mass effectiveness Administer med 1/2 SR's (siderate as enablers Therapy as ord	rogress note, dated at the resident had he seemed to be re. A physician's on 7/15/10 indicated implained of left knee arthritis and knee pain. In a per mark to the resident go Depomedrol (steroid at left knee. I dated 3/1/11, indicated do complaints of chronic imorbid obesity, re, and impaired mobility the resident to have belief as evidenced by int quarterly/prn and record). Interventions allowing: cord any complaints of duration, quantity, ing factors, aggravating imeasures: distraction, isage, TV. Monitor dications as ordered ails) and trapeze bar			for 4 weeks. The audit will then proceed to a minimum of flow sheets monthly for an additional 11 months. The Director of Nursing or her designee will review the pain assessments and pain management programs for at least 5 residents with new or increased pain weekly for 4 weeks and then 5 residents monthly for 11 months to mon effectiveness. The Therapy Supervisor will monitor a minimum of 2 dressing change provided by therapy weekly fo weeks then 2 dressing change per month for a total of 12 monto observe for any pain issues	itor es r 4 es nths		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING		COMPL		
		155333	B. WING			03/04/2	011	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE			
DAOLLU	PAOLI HEALTH AND LIVING COMMUNITY INC				LONGEST ST			
	EALTH AND LIVING	3 COMMUNITY INC			IN47454			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG	signs of pain:	· · · · · · · · · · · · · · · · · · ·	+	TAG	,		DATE	
		essness, grimacing,						
	diaphoresis, wi	•						
	•	al therapy for muscle						
	strengthening,							
	mechanics, and	•						
	· ·	ent quarterly and prn.						
	1 4111 4556551116	m quartory and pin.						
	The February 2	2011 MAR indicated						
	1	ts were administered						
	1 -	30 p.m. The "Nurse's						
		tes," used to document						
		given and response						
		f with instructions to,						
		needed) monitoring						
	· '	RN Pain Assessment						
	Monitoring For							
		of the administration						
		dication on 2/7/11,						
	including the ne							
	_	empted prior to						
		of the medication and						
		the medication, and						
		was lacking in the						
	nurses notes.	Ü						
	Nurses notes of	on 2/15/11 at 1:00 p.m.						
	indicated the re	•						
	complaining of	right shoulder pain and						
		vas notified and a new						
	order was obta	ined on 2/16/11 for an						
	x-ray of the sho	oulder. Documentation						
	of a complete a	assessment of the pain						
	was lacking on	•						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED	
		155333	B. WIN	G		03/04/2	011
NAME OF I	PROVIDER OR SUPPLIER	: }			ADDRESS, CITY, STATE, ZIP CODE		
546111	- A I - T. I - A N I D - I D / I N / I N / I			1	LONGEST ST		
PAOLIH	EALTH AND LIVING	G COMMUNITY INC		PAOLI,	IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIAC I)		DATE
	documentation and response t discussed with Nurses). She i	00 p.m., the lack of of assessment of pain to treatment was the DoN (Director of Indicated she was e any additional review.					
	was reviewed of The resident's	record of Resident #74 on 3/3/11 at 3:05 p.m. diagnoses, included mited to, Chronic Pain					
	following pain r 11/10/10 - Tyle mg (milligrams (four times dail Tylenol 325 mg (hours) as need	enol Extra Strength 500) 1 po (by mouth) qid y) g 2 po q (every) 4 hrs					
	2/18/11, indica severe arthritis	rogress note, dated ted the resident had ; "I asked if wants No I'm afraid of taking cine."					
	"Resident has having chronic	nted 2/28/11, indicated, increased risk of pain diagnosis of rndrome," with a goal					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)			ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		COMPLETED	
		155333	B. WIN			03/04/201	1
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	S.			LONGEST ST		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		to verbalize pain is at					
	manageable le	vels as evidenced by					
	the pain scale.	Interventions					
	including the fo	llowing:					
	Monitor and red	cord any complaints of					
	pain: location,	frequency, effect on					
		ity, alleviating factors,					
	aggravating fac	•					
	""	cord any non-verbal					
		e.g., crying, guarding,					
	,	essness, grimacing,					
	_	thdrawal, etc.).;					
	I	cated pain relief					
		ssage, physical					
		ning and strengthening					
	exercises, repo	• •					
	Monitor effective	•					
		dications: Tylenol,					
	vitamin B.	dications. Tylenol,					
		cord effectiveness.					
	Report adverse						
	· ·	nfort; therapy screen					
	quarterly and p						
	' ' '	•					
		iveness of pain					
	management ir						
		ctive or adverse side					
	effects emerge						
	Stand-up lift wi	·					
	Contact MD/far	mily prn					
	The January 20	011 MAR indicated					
	1	mg) was given on					
	l ,	0 p.m. There was no					
		the pain, including					
	•						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155333	B. WIN			03/04/20	011	
NAME OF P	ROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE	•		
DAOLLUI		G COMMUNITY INC		1	LONGEST ST IN47454			
					11147454			
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD				
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	location, severi	ty, and effect on the						
	resident, docun	nentation of						
	non-pharmacol	ogical interventions						
	attempted prior							
		or effectiveness of the						
		cumented on the MAR						
	and the "Pain F 2011 was blank	Flow Sheet" for January						
	LOTT WAS DIAIL	١.						
	On 3/3/11 at 4:	00 p.m., the lack of						
		of assessment of pain						
	and response to	o treatment was						
		the DoN (Director of						
	,	ndicated she was						
		e any additional						
	information for	review.						
	4. The "Pain M	lanagement						
	Program" polic	cy, dated 3/10, was						
	provided for re	eview on 3/3/11 at						
	4:00 p.m. The	policy included, but						
	was not limited	d to, the following:						
	"DDN Doin Mar	dication						
	"PRN Pain Med	uication-						
	When analgesi	ics are administered						
	in response to	an episode of pain,						
	nurses must d	ocument their						
	•	reatment, and the						
		of the treatment on						
	the PRN pain a							
	monitoring for	m.						
	The form requi	ires documentation						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC			LONGEST ST IN47454		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤЕ	(X5) COMPLETION DATE
	of the following	g information:					
	* Date and time * Site of pain * Non-pharmac provided * Source of infermity/resident ed pain) * Pain type * Pain medicat * Level of sedat * Pain rating 0- 2. Effectivenes * Side effects * Response (30)	cological treatments ormation- t/assessment(perceiv ion given tion -10 ss of treatment 0-60 min. after ministration)- pain					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155333	B. WING			03/04/2011	
			D. W.1.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LONGEST ST		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PRO		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0314	Based on obse	rvation, interview, and	F03	14	F314		04/03/2011
SS=D	record review, t	the facility failed to			483.25(c)TREATMENT/SCVS		
00 D	provide treatme	ent to prevent infection			PREVENT/HEAL PRESSURE		
	and promote he	•			SORESI.Resident #55 no long resides at the facility. Resider		
	-	wed for pressure ulcers			#62 and #113 have an update		
		3 who met the criteria			plan of care for pressure ulcer		
	•	res [Residents #113			treatment and prevention.		
	•	=			Resident #113 has an updated	t l	
	<u>-</u> :	iled to prevent the			assessment of the wound.		
	•	f pressure ulcers for 1			Resident #100 does not have	any	
		eviewed for pressure			pressure ulcers and has an		
	ulcers who met	the criteria for			updated prevention of pressur		
	incidence or wo	orsening of pressure			ulcer care plan.II.The facility h completed new Skin At Risk	as	
	ulcers in a sam	ple of 3 [Resident			assessments for all residents	and	
		3 residents in a			updated the care plans for tho		
	_	ample of 3 residents			residents at risk for skin		
	reviewed for pr	•			breakdown. All current reside	nts	
	•				with pressure ulcers have an		
	[Resident #62].				updated assessment of the		
					wound prior to any treatment		
	Findings includ	e:			changes. All current treatmen	ts	
					to pressure ulcers are being		
	 During obse 	ervation on 3/3/11 at			conducted in a manner to prev	rent	
	8:12 A.M., Res	ident #113 being			infection and promote healing.III.The systemic chang	ا وام	
	wheeled from b	oreakfast in the MDR			that the wound nurse will asse		
	and was placed	d just outside the door			and document weekly on all		
	•	he resident was taken			pressure areas being treated to	_{oy}	
		apy for pressure ulcer			therapy. In addition, 5 days a	.	
					week nurse management will		
	treatment at 9 A.M.				review the 24 hour report book		
	The allies - I -	and of Danislant #440			for new or worsening pressure		
		ord of Resident #113			ulcers and new treatment orde		
		on 3/3/11 at 8:30 A.M.,			and audit the appropriate char proper assessment of the	i 101	
		the resident was			wound. All dressing changes	_{are}	
	admitted to the	facility 3/25/10			now being conducted in the		
	following hospit	talization for an acute			resident's room. Nursing		
	heart attack. Of	ther diagnoses			education has been provided		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED		
		155333	B. WIN			03/04/2	011	
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	R			LONGEST ST			
DAOLLH		G COMMUNITY INC		1	IN47454			
	LALIII AND LIVIN	3 COMMONTT INC		I AOLI,				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
	· · · · · · · · · · · · · · · · · · ·	ot inclusive were			regarding documentation of			
	moderate dem	entia, hypertension,			assessment, treatment and appropriate infection control			
	DJD [degenera	ative joint disease],			during wound care. Therapy h	nas		
	COPD [chronic	obstructive pulmonary			been provided education on	140		
	disease], hypo	thyroidism and anxiety.			communicating any changes i	n		
		ad been living at home			wounds to nursing as well as			
		the hospitalization.			wound treatment and			
					assessment. Education for			
	Nurses notes o	lated 1/22/11, at 0230			licensed nurses included care			
		•			planning, prevention, treatmer and assessment of pressure	ìτ		
		icated, "Res [resident]			areas.IV.The Unit Managers of	r		
		aff changes res q			their designee will audit the ch			
		& repositions her or			of all new residents,			
	· ·	care. Incont B & B			readmissions, and residents w	vith .		
	[incontinent of	bowel and bladder].			significant change for care pla	ns		
	Found area on	right buttock/hip area.			and/or care plan updates			
	Measures 5 CN	M [centimeters] x 5 CM			regarding pressure sore			
	reddened line,	.5 cm width, 0 depth, &			treatment and prevention 5 da	ys		
	another 5 cm x	5 cm .5 cm width c			a week at the daily clinical meeting for 12 months. Woun	d		
	[with] small sca	abs & reddened.			care documentation, with	u		
		e area is hard, approx.			emphasis on changes,			
		unded. Res claims no			assessment and treatment wil	l be		
					audited weekly per nursing			
		ess s/s [signs or			administration for 12 months.1	he		
	symptoms] obs	oci veu.			Director of Nursing or her			
					designee will audit a minimum			
		care of the pressure			3 dressing changes for proper assessment, treatment and			
		at 9:43 A.M., indicated			infection control technique we	eklv		
	physical therap	by was to perform the			for 4 weeks, then a minimum	•		
	treatment. Phy	sical therapist [PT] #1			monthly for 4 months, then on			
	indicated diath	ermy (deep heat			time a month for a total of 12			
	therapy to increase circulation to an				months of monitoring. The			
	· ·	ace. The resident was			Therapy Supervisor will obser			
	lying on her left side in a bed. There				dressing changes weekly for 4			
	was an incontinent brief rolled under				weeks for proper assessment,			
		id visible brown			treatment and infection contro techniques. The audit will the			
	uicicoluciil dii	id visible blowii			Tooriniques. The audit will the	''		
			1		I			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155333		A. BUILDING 03/04/2011			
		100000	B. WIN		A DEPENDE OF THE CORE	03/04/20	711
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LONGEST ST		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC		1	IN47454		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The wound was and had depth. wound just ope debridement the indicated the wound was diameter. There was redressed wound extending of the wound. It indicated the wound extending of the wound. It indicated the resident near the came down continues to confeces in her brief the previous continued on wo open wound with incontinent brief area of the would the resident was a fall of the would be a fall of the world be a fall of the would be a fall of the world b	on the brief. s on the right ischium PT#1 indicated the ned up after e current week and ound was 1 cm deep. s round with a 2 cm ness surrounding the ng 5 cm the diameter The woundbed had e that moved around the therapy d the staff upstairs that eded cleaned before n for treatment, but she me to therapy with ef. The resident had erapy with feces in her us day, also. PT #1 ith the treatment of the th the feces on the ef in the immediate			continue for a minimum of 2 dressing changes a month for months. The results of the audi will be reviewed in the facility monthly Quality Assurance Committee meeting and the frequency and duration will be adjusted after review.	its	

PRINTED: 03/25/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER	G COMMUNITY INC	STREET.	ADDRESS, CITY, STATE, ZIP CO LONGEST ST IN47454	DDE		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR treatment should feces in the area way the resident treatment. PT staged the would linterview with the staged the would feces in the area way the resident treatment. PT staged the would feces in the area way the resident treatment. PT staged the would feel the reduce with the sent to the rapy episode. She had cleaning the resident feel the reduces subtential to the plant of the reduce with the reduce with the reduce with the resident feel the would care not assessment. So the would care assessing the would care assessing the would seen the would	ATTEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Id not be done with ea, but that was the nt was sent for #1 indicated she and as a Stage 3. The charge nurse, LPN Resident #113 at 10:08 Indicated she had not resident had ever been with an incontinent had assisted staff in sident of feces before LPN #1 at the time hysician was aware of rrounding the wound, know if the resident by the physician The DoN on 3/3/11 at ated she and the rese had just talked ent's wound Starting next Monday,	559 W	LONGEST ST	ECTION DULD BE	(X5) COMPLETION DATE	
		icked up a resident for did the assessments.					

000226

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		DNSTRUCTION	ſ ′	(X3) DATE SURVEY COMPLETED		
155333	A. BUILDING B. WING		- 03/04	1/2011		
	559 W I	LONGEST ST	ODE			
Provided to the control of the contr	PAOLI, ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE		
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: 155333 IDENTIFICATION NUMBER: 155333 IDENTIFICATION NUMBER: NG COMMUNITY INC IDENTIFICATION NUMBER: NG COMMUNITY INC IDENTIFICATION NUMBER: STREET. ST	IDENTIFICATION NUMBER: 155333 IDENTIFICATION NUMBER: 155333 IDENTIFICATION NUMBER: 155333 IDENTIFICATION NUMBER: 1559 W LONGEST ST PAOLI, IN47454 PAOLI, IN47454 PREVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICIENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICIENCY) PREFIX TAG PREVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICIENCY) PREFIX TAG PREVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICIENCY) PREFIX TAG PREVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICIENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICIENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICIENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICUENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICUENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICUENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICUENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE A DEFICUENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORE PACTOR SIN CROSS-REFERENCED TO THE A DEFICUENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORE PACTOR SIN CROSS-REFERENCED TO THE A DEFICUENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORE PACTOR SIN CROSS-REFERENCED TO THE A DEFICUENCY) PREFIX TAG PROVIDENS PLAN OF CORE (EACH CORE PACTOR SIN TAG PROVIDENT PACTOR SIN TAG PROVID	IDENTIFICATION NUMBER: 155333 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE S59 W LONGEST ST PAOLI, IN47454 IDENTIFYING INFORMATION OR LSC IDENTIFYING INFORMATION OR LSC IDENTIFYING INFORMATION NON-PRESSURE VENTION AND NT PROGRAM," //4/11 at 7:50 A.M. and Oh. A.M., indicated "Skin or Ly Treatment, Protection, irom exudates, and incontinence." IS ULCER TREATMENT, sement and on: When assessing a occumenting findings, ollowing factors: ness or warmth to touch infection." all record of Resident riewed on 3/3/11 at 3 icoted the resident thad ulcer on admission in 010. The admission in oil oil oil of the resident was at risk for as, but had no pressure Wound Evaluation		

NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN47454 (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY INC SLMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Left Heel 10/4/10 SDTI [Suspected Deep Tissue Injury] 2.5 x [by] 2.2 cm [centimeter] x < .1 cm depth 10/11/10 unstageable 22 x 2.2 10/18/10 sdti 2.2 x 1.4 11/15/10 1.8 x 1.6 11/22/10 .5 x 1.1 Stage 2 11/29/10 .6 x .4 stage 2 12/6/10 healed Right Heel 10/4/10 2.6 x 3 sdti 10/11/10 unstageable 3.3 x 3 10/19 healed The facility obtained physician's orders for Vitamin C and Zinc for 30 days and foam dressing to bilateral heels, change q [every] 7 days on 10/4/10. Additional orders were received on 10/13/10 to continue physical therapy including there ex [therapeutic exercise], neuro [neurological re-training], and gait training for 3 x wk x 2 wks [three times a week for two weeks].			155333	1			03/04/2	011	
PREFIX REGILATORY OR LSC IDENTIFYING INFORMATION) Left Heel 10/4/10 SDTI [Suspected Deep Tissue Injury] 2.5 x [by] 2.2 cm [centimeter] x <1.1 cm depth 10/11/10 unstageable 2.2 x 2.2 10/18/10 unstageable 2.2 x 2.7 11/1/10 unstageable 2.3 x 2.7 10/25/10 2.2 x 2.7 11/1/10 unstageable 2.2 x 2.1 11/18/10 sdti 2.2 x 1.4 11/15/10 1.8 x 1.6 11/22/10 .5 x 1.1 Stage 2 11/29/10 .6 x .4 stage 2 12/6/10 healed Right Heel 10/4/10 2.6 x 3 sdti 10/11/10 unstageable .3 x. 3 10/19 healed The facility obtained physician's orders for Vitamin C and Zinc for 30 days and foam dressing to bilateral heels, change q [every] 7 days on 10/13/10 to continue physical therapy including there ex [therapeutic exercise], neuro [neurological re-training], and gait training for 3 x wk x 2 wks [three times a week for two weeks].				559 W LONGEST ST					
	PAOLI H (X4) ID PREFIX	EALTH AND LIVING SUMMARY S' (EACH DEFICIEN REGULATORY OR Left Heel 10/4/10 SD Tissue Injury] 2 [centimeter] x 10/11/10 unst 10/18/10 2.2 x 11/1/10 unst 11/8/10 sdti 11/15/10 1.8 x 11/22/10 .5 x 11/29/10 .6 x 12/6/10 ft Right Heel 10/4/10 2.6 10/11/10 unst 10/19 head The facility obtained and heels, change (10/4/10). Additional order 10/13/10 to corincluding there exercise], neuropertraining], and	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) TI [Suspected Deep 2.5 x [by] 2.2 cm <.1 cm depth ageable 2.2 x 2.2 ageable 2.3 x 2.7 (2.7 ageable 2.2 x 2.1 2.2 x 1.4 (1.6 1.1 Stage 2 4 stage 2 healed ained physician's hin C and Zinc for 30 dressing to bilateral q [every] 7 days on rs were received on hitinue physical therapy ex [therapeutic to [neurological d gait training for 3 x	PI	PAOLI, ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
Record indicated on 10/6/10, areas to		The Weekly Wo							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE COMP	
		155333	A. BUILDING B. WING		03/04/2	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	·	
PAOLI HI	EALTH AND LIVING	G COMMUNITY INC	l l	LONGEST ST , IN47454		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	· 	OV.	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO) BE	COMPLETION
TAG		"Resd [resident] digs	TAG	DEFICIENCY)		DATE
		ir mattress applied,				
	also has padded w/c pedals & OT [occupational therapy] is to assessing if w/c [wheelchair] pedals can be					
	removed."	aiij pedais caii be				
	Observation 3/3	3/11 at 1:30 P.M.				
		was a trapeze on the				
	• •	eduction mattress on one on the one				
	the foot pedals					
	3/4/11 indicated	he DoN at 2 P.M. on d the resident had heel wounds and was it had been				
	the resident dig mattress. She	wounds were due to ging her heels into the stated the resident had				
	the evaluation.	ved to do so prior to				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155333	B. WIN			03/04/2011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			l	LONGEST ST	
PAOLLH	FALTH AND LIVING	COMMUNITY INC		l	IN47454	
				Ĺ		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
F0314		t 3:18 p.m., the LPN	F03	14	F314	04/03/2011
SS=D	(Licensed Prac	tical Nurse) caring for			483.25(c)TREATMENT/SCVS PREVENT/HEAL PRESSURE	
	Resident #55, i	ndicated the resident			SORESI.Resident #55 no long	
	had a Stage 3	oressure ulcer on her			resides at the facility. Resider	•
	соссух.				#62 and #113 have an update	
	,				plan of care for pressure ulcer	
	On 3/3/11 at 10):00 a.m., LPN #3 was			treatment and prevention.	
		mplete the treatment			Resident #113 has an updated	d
		5's pressure ulcer.			assessment of the wound.	
		•			Resident #100 does not have	any
	•	ocolloid dressing was			pressure ulcers and has an updated prevention of pressur	_
	•	nurse, the area on			ulcer care plan.II.The facility h	
	•	asured approximately 3			completed new Skin At Risk	
	-	n) by 2 centimeters			assessments for all residents	and
	and was black	in color with several			updated the care plans for tho	se
	smaller, red, op	en areas around the			residents at risk for skin	
	perimeter of the	e wound. All areas			breakdown. All current reside	nts
	were cleaned w	vith normal saline and			with pressure ulcers have an	
	a clean hydroco	olloid dressing was			updated assessment of the wound prior to any treatment	
	replaced over t				changes. All current treatmen	te
	ropiacoa ovoi a	no wodila.			to pressure ulcers are being	13
	The clinical rec	ord of Resident #55			conducted in a manner to prev	rent
					infection and promote	
		on 3/3/11 at 11:15 a.m.			healing.III.The systemic chang	je is
		diagnoses included,			that the wound nurse will asse	ss
	but were not lin				and document weekly on all	
		ar Disease, and Atrial			pressure areas being treated to	Dy
	Fibrillation.				therapy. In addition, 5 days a week nurse management will	
					review the 24 hour report book	(9
	A physician's o	rder, dated 3/3/11 at			for new or worsening pressure	
		icated the following:			ulcers and new treatment orde	
	, -	3			and audit the appropriate char	t for
	Discontinue pre	evious treatment to			proper assessment of the	
	•	with normal saline,			wound. All dressing changes	are
	•				now being conducted in the	
		ebriding agent) to			resident's room. Nursing	
	coccyx wound I	bed only and cover			education has been provided	

AND PLAN OF CORRECTION IDENTIFICATION NUM				COMPLE	TED
155333	A. BUI	ILDING		03/04/20	
100000	B. WIN			00/01/20	
NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
PAOLI HEALTH AND LIVING COMMUNITY IN	C	1	LONGEST ST IN47454		
					(V.S.)
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PERCEDE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFO		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
with adhesive foam dressing ev			regarding documentation of		BIIIE
day and as needed for soiling of	· ·		assessment, treatment and		
dislodgement.)		appropriate infection control		
dislougement.			during wound care. Therapy h	ias	
There was no documentation o	of on		been provided education on		
			communicating any changes in wounds to nursing as well as	1	
assessment of the wound in the			wound treatment and		
nurses notes at the time the ne			assessment. Education for		
treatment was obtained from th	ie		licensed nurses included care		
physician on 3/3/11. The last			planning, prevention, treatmen	t	
documentation of an assessme			and assessment of pressure areas.IV.The Unit Managers of	.	
the wound was on the "Weekly			their designee will audit the ch		
Wound Evaluation Flow Record	· I		of all new residents,		
was dated 2/28/11. This asses			readmissions, and residents w		
indicated the wound measured			significant change for care plan	ns	
(centimeters) by 08. cm, withou			and/or care plan updates		
depth indicated. The assessme			regarding pressure sore treatment and prevention 5 da	vs	
indicated the wound was Stage	I		a week at the daily clinical	, ,	
the wound bed was yellow with	· I		meeting for 12 months. Woun	d	
noted around the wound and ye	ellow		care documentation, with		
drainage noted.			emphasis on changes,		
			assessment and treatment will audited weekly per nursing	be	
On 3/4/11 at 9:50 a.m. the DoN			administration for 12 months.T	he	
(Director of Nurses) was intervi	iewed		Director of Nursing or her	-	
regarding the lack of an assess	sment		designee will audit a minimum		
regarding wound prior to chang	ging the		3 dressing changes for proper		
treatment on 3/3/11 and the pre	esence		assessment, treatment and		
of additional red, open areas a	round		infection control technique wee for 4 weeks, then a minimum of	· 1	
the blackened pressure sore du	uring		monthly for 4 months, then one		
observation of the treatment. S	She		time a month for a total of 12		
indicated the treatment change	came		months of monitoring. The		
as a result of conversation with	ı [Therapy Supervisor will observ		
hospice on Monday after the W	ound		dressing changes weekly for 4 weeks for proper assessment,		
Nurse discussed the condition			treatment and infection control		
wound with hospice after doing	the		techniques. The audit will ther		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING		COMPLETED
		155333	A. BUI B. WIN			03/04/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L.		1		
DAGLLU		C COMMUNITY INC		1	LONGEST ST	
PAULI HI	EALTH AND LIVING	G COMMUNITY INC		PAULI,	IN47454	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	treatment. She	e indicated hospice			continue for a minimum of 2	
.	hadn't gotten a change in treatment				dressing changes a month for	l l
		ay. At approximately			months.The results of the aud	its
	1	DON indicated she			will be reviewed in the facility	
					monthly Quality Assurance	
		Wound Nurse, and			Committee meeting and the	
		ment her conversation			frequency and duration will be	
	with hospice or	n Monday.			adjusted after review.	
	4. The clinical	record of Resident #62				
	was reviewed o	on 3/4/11 at 10:14 a.m.				
	The resident wa	as admitted to the				
		6. The care plan for,				
		in breakdown, dated				
		•				
	7/16/09, and up	_				
	· ·	ted the resident was				
	up ad lib with l	RW" (up as desired				
	with rolling wall	ker).				
	Nurses notes ir	ndicated the resident				
	sustained a fall	with fracture of the				
		turned from the				
		/11. The nursing				
	· •	•				
		sessment, dated,				
	· ·	ed the resident had a				
	' '	circular area (R) (right)				
	buttock" when	she returned from the				
	hospital. A trea	atment order of Zinc				
		ttocks was obtained at				
	the time of read					
	The nursing reg	admission assessment,				
	l '	ndicated the resident				
	_	t bearing on the right				
, l	leg related to th	ne fracture. The care				

000226

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE : COMPL	
		155333	A. BUI B. WIN	LDING	=	03/04/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			1	LONGEST ST		
		G COMMUNITY INC		1	IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG			-	TAG	Dia relative 17		DATE
		al for skin breakdown					
	was not changed at the time of readmission. On 2/11/11, Hydrocodone 7.5/325 (pain medication) was ordered for the						
	**	I as an ace wrap from					
		the thigh related to					
	_	a. On 2/17/11, the					
	•	n was ordered to be					
	· •	s daily routinely.					
		o dany rodaniory.					
	On 2/18/11. at	12:35 (no a.m. or p.m.					
		es notes indicated the					
	,	n "Area noted to (L)					
		ock 1.7 x (by) 0.6 x <					
	` '	Full layer of skin					
	, ,	nas scant amt (amount)					
	of drainage. W	•					
	periwound is pi	nk. [No] pain noted					
	[with] assessm	ent. Res (resident) has					
	recent fx (fractu	ure) and is now					
	dependent on s	staff for transfers, T &					
	R (turning and	repositioning); and					
	toileting. Fx (fr	acture) of (R) femur					
	,	to multiple sides.					
	Staff aware of i	•					
	A "Weekly Woι	and Evaluation Flow					
	Record," dated	2/18/11, indicated the					
	resident had a	stage 2 pressure ulcer					
	on the inner lef	t buttock.					
	On 2/18/11, a c	care plan was initiated					

000226

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CO	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COLONGEST ST		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR for, "Resident h' R/T (related to) ." Documentat plan of care wa resident develo On 3/4/11 at 12 (Director of Num talked to the num readmission as Resident #62 re fracture, and the		559 W		DDE ECTION JULD BE	(X5) COMPLETION DATE

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155333	B. WIN			03/04/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				LONGEST ST	
		G COMMUNITY INC			IN47454	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)	DATE
F0329	Based on recor	d review and interview,	F03	29	F329 483.25(I)DRUG REGIME	
SS=D	the facility failed	d to monitor 2 of 10			IS FREE FROM UNNECESSA	
	residents, in a s	sample of 10 residents			DRUGSI.The blood pressure a pulse of resident #42 was	ina
	reviewed who r	net the criteria for			monitored 6 times between	
	unnecessary m	edications, for			2/28/11 and 3/4/11 and was	
	monitoring of bl				documented in the computeriz	ed
	_	sident # 42) and			Matrix Documentation System	
	unnecessary us	•			utilized by the facility. A gradu	
	_	ication (Resident #54).			dose reduction was completed	for
	Stabilizing medi	ication (Resident #54).			resident #54.II.The facility has reviewed all residents on	
					psychoactive medications for	
	Findings include:				gradual dose reductions and	
					addressed as needed. All	
	The clinical rec	ord for Resident # 42			residents receiving blood	
	was reviewed o	on 3/3/11 at 2:45 p.m.			pressure medication have thei	r
	The resident ha	ad diagnoses which			blood pressure monitored at le	I
	included, but w	ere not limited to: high			weekly.III.The systemic chang	
	blood pressure.	, weakness, coronary			that monthly reviews of gradua	11
	•	gastro-esophogeal			dose reductions will occur between the consultant	
		depression, heart			pharmacist, social services an	d
		nia, right ulna fracture,			nursing. The systemic change	I
	•	cell carcinoma, and			also includes adding residents	
	atypical psycho	·			who have changes in blood	
		, J.			pressure medications to acute	
	The physician t	alanhana ardara			charting to monitor their blood	
		elephone orders,			pressure per policy. Social Services has initiated a gradua	
		increased the blood			dose reduction tracking tool.	41
	•	ng medication, Imdur,			Social Services and nursing st	aff
	_	ms to 30 milligrams			have been provided education	<u> </u>
	•	order indicated it was			regarding gradual dose	
	changed to the	higher dose to lower a			reduction. Nursing staff was	
	rapid pulse rate	e. In addition, the			provided education in blood	
	resident was re	ceiving a Nitro-patch			pressure and pulse monitoring	
		4 micrograms per hour			after medication changes that affect blood pressure and/or	
		10 milligrams twice			pulse.IV.The Director of Nursir	ng
		ese medications were			or her designee will monitor by	-

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	155333	A. BUILDING			03/04/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/0 // 2011	
NAME OF P	PROVIDER OR SUPPLIER			1	LONGEST ST		
PAOLI HI	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
TAG		· · · · · · · · · · · · · · · · · · ·	+	TAG	reviewing all orders for a chan		
		ne blood pressure. Il and Imdur lower the			in blood pressure medication	90	
	pulse rate as w				and reviewing for appropriate		
	puise rate as w	CII.			monitoring of vital signs 5 days		
	The nursina no	tes, treatment record,			week. An audit for appropriate monitoring of blood pressure	;	
	_	record for February,			medication will occur for a		
	2011 and Marc	_			minimum of 10 residents		
	reviewed. The	re was no blood			receiving these medications weekly for 4 weeks and then 1	0	
	pressures or pu	ulses recorded for the			residents monthly for a total		
	resident from th	ne time of the order			duration of 12 months. The		
	_	d of the survey on			facility will audit 100% of the residents receiving psychoacti	VO.	
	3/4/11.				medications for gradual dose	ve	
					reduction and then review		
	The Director of	_			monthly thereafter. The results	•	
		3/3/11 at 3:30 p.m.			this audit will be reviewed in the facility monthly Quality Assura	•	
		the blood pressure			Committee meeting and the	1100	
	and pulse sho				duration and frequency of the		
		he dosage change of			audits adjusted after review.		
	the medication	l.					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SUF COMPLETI	
		155333	A. BUII B. WIN			03/04/201	1
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	LONGEST ST		
PAOLI H	EALTH AND LIVING	G COMMUNITY INC			, IN47454		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329		cord review was done	F03	29	F329 483.25(I)DRUG REGIME		4/03/2011
SS=D	on 3/2/11 at 2 p	o.m. for Resident #54			IS FREE FROM UNNECESSA DRUGSI.The blood pressure a		
	and included th	e following: Annual			pulse of resident #42 was	110	
	MDS (minimum	ı data set) diagnoses			monitored 6 times between		
	included but no	t limited to Alzheimer's			2/28/11 and 3/4/11 and was		
	dementia with b	oehavioral disturbance.			documented in the computeriz		
	A record titled "	Psychiatric Evaluation			Matrix Documentation System		
	dated 7/6/2009	indicated resident			utilized by the facility. A gradu dose reduction was completed		
	referred due to	anxiety mood			resident #54.II.The facility has		
		neffective participation			reviewed all residents on		
		eported she was			psychoactive medications for		
		constant request, and			gradual dose reductions and		
	•	e leaving the dining			addressed as needed. All		
	room due to he				residents receiving blood	_	
		nmary: In summary			pressure medication have thei blood pressure monitored at le		
		aving problems with			weekly.III.The systemic chang		
	affective and co	.			that monthly reviews of gradua		
	concernsRec	•			dose reductions will occur		
					between the consultant		
	Therapy shou				pharmacist, social services an nursing. The systemic change		
	•	vioral, insight oriented,			also includes adding residents		
	• •	perspectives. Mental			who have changes in blood		
	status is not con				pressure medications to acute		
		therapy at this point.			charting to monitor their blood		
	• •	pear to be generally			pressure per policy. Social	_	
		hough the addition of a			Services has initiated a graduation tracking tool	ai	
		may be beneficial. A			dose reduction tracking tool. Social Services and nursing st	_{aff}	
	• •	originally dated			have been provided education		
		ted Depakote 125 mg			regarding gradual dose		
	(milligram) BID	(twice daily). A review			reduction. Nursing staff was		
	of the clinical re	ecord from April 2010			provided education in blood		
	to current did no	ot have any			pressure and pulse monitoring		
		of behaviors present.			after medication changes that affect blood pressure and/or		
		ow record for the			pulse.IV.The Director of Nursir	ng	
	month of Decer	mber 2010 to to March			or her designee will monitor by	-	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CORRECTION	155333	A. BUII	A. BUILDING		COMPLETED 03/04/2011	
		199393	B. WIN			03/04/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
 ₽∆∩⊥H	EALTH AND LIVING	G COMMUNITY INC		1	LONGEST ST IN47454		
				<u> </u>			QUE)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
		no behaviors. The			reviewing all orders for a chan	ge	
		gement team review			in blood pressure medication		
	dated Dec 2010	•			and reviewing for appropriate		
		urrent care plan in			monitoring of vital signs 5 days week. An audit for appropriate		
		ndicated"Review			monitoring of blood pressure	^	
	medications for				medication will occur for a		
		ast every 6 months"			minimum of 10 residents receiving these medications		
	During on inter	viow with the social			weekly for 4 weeks and then 1	0	
		view with the social on 3/3/11 at 8:50 a.m.			residents monthly for a total duration of 12 months. The		
		ne resident has not			facility will audit 100% of the		
		pehaviors in the last			residents receiving psychoacti	ve	
	, , ,	nd has been on			medications for gradual dose		
		d is monitored thru the			reduction and then review monthly thereafter. The results	of	
		am. The social service			this audit will be reviewed in the		
	was unable to I				facility monthly Quality Assura	nce	
	resident last sh	owed behavioral			Committee meeting and the		
	symptoms or w	hen the last GDR			duration and frequency of the audits adjusted after review.		
	(gradual dose r	eduction) of Depakote			addito adjusted after review.		
	was attempted	and/or					
	contraindicated	l.					
	1 -	view with the DNS on					
		0 p.m she indicated					
		e to locate any reason					
		on for why GDR for					
		not been attempted for					
		n the absence of					
	behaviors.						
	3.1-48(a)(2)						

000226

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		•	559 W I	ADDRESS, CITY, STATE, ZIP CODE LONGEST ST IN47454		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Based on obsethe facility failed nursing hours who basis. This was days and had the 100 of 100 residence facility. (3/1/11 addition, the facility. (3/1/11 addition, the facility addition, the facility addition, the facility addition. Findings included and ural survey days (3/4/11). Findings included During the initial 3/1/11 at 9:05 as staffing posting was for the night dated 2/28/11. On 3/3/11 at 7:1 the facility, nursiting the 100/300 unit for the night shift way at 4:15 p.n. The nursing staffing sta	ECOMMUNITY INC FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) rvation and interview, d to ensure total were posted on a daily s observed on 2 of 4 he potential to affect dents residing in the and 3/3/11). In cility failed to ensure ffing posting contained hours worked for filicensed staff on 4 of (3/1, 3/2, 3/3, and) e: al tour of the facility on a.m., the nursing on the 100/300 units ht shift only and was 55 a.m., upon entry to sing staffing posting at its was completed only ift and remained this h. on 3/3/11.	F03	559 W I PAOLI, ID PREFIX TAG		RSE The the the ting h nge peen nd on. en sting for h east	(X5) COMPLETION DATE 04/03/2011
	contain the total actual hours worked for licensed or unlicensed nursing staff on any day of the survey, 3/1, 3/2, 3/3, and 3/4/11 upon entry to the facility at 8:00 a.m. each day.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE COMPI	
111,2 12,111	or condition	155333	A. BUILDING B. WING		03/04/2	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_!	
PAOLI H	EALTH AND LIVING	G COMMUNITY INC		LONGEST ST IN47454		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	COMPLETION DATE
IAU	The Director of interviewed on concerning the information. SI had posted the	Nursing was 3/4/11 at 2:15 p.m. posting of staffing he indicated the facility number of hours per not the total number of	IAU			DATE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 03/04/2011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LONGEST ST		
PAOLI HEALTH AND LIVING COMMUNITY INC				I	IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		,	DATE 04/02/2011	
F0371		rvation, record review,	F0371		F371 483.35(i)FOOD PROCURE, STORE/PREPARE/SERVE-SANI		04/03/2011
SS=E	<u>-</u>	the facility failed to			TARYI.The facility is now utiliz		
		milk products at a			a drink cart for milk and insula		
	•	prevent foodborne			bowls for milk products, such a		
	bacteria growth	ect 58 of 58 residents			pudding.II.All milk products are currently being served at a	;	
	•	eals in their rooms out			temperature to prevent foodbo	rne	
		residents who received			bacteria growth.III.The system		
	food from the k				change is that the facility is	:11.	
	lood from the k	itorion.			utilizing drink carts for milk. M products, such as pudding, are		
	Findings includ	۵.			being served in insulated bowl		
	i inanigo inolaa	C .			and are taken out of refrigerati		
	During observa	ition on 3/3/11 at 11			immediately prior to serving.		
	_	vice was beginning.			Dietary staff were provided education regarding the syster	n	
		re of food products had			and the reason for keeping mil		
	•	or to tray preparation			products at appropriate		
	and indicated the	• • •			temperature.IV.The Certified		
		nheit [F]. Interview			Dietary Manager will randomly		
		ed Dietary Manager			monitor the temperature of mil and milk products a minimum		
	[CDM] during the				times weekly for 4 weeks, ther		
		were 58 residents who			time a week for 4 months and		
	received trays i				monthly thereafter for a total o		
					months monitoring. The results the audit will be reviewed at the		
	A test trav was	requested for the 300			facility monthly Quality Assura		
	_	cart. The cart left the			Committee meeting and adjust		
	•	3 A.M. and arrived at			as needed.		
		11:44 A.M. Staff were					
		hall and started					
	•	s from the cart at					
		e cart used to transport					
		nad no heating or					
	cooling environ	_					
	The last tray wa	as served to a resident					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
155333		B. WING		03/04/2011		
NAME OF I	DROVIDED OD SLIDDLIED		STREET	ADDRESS, CITY, STATE, ZIP CODE	. L	
NAME OF PROVIDER OR SUPPLIER			559 W	LONGEST ST		
	EALTH AND LIVING	G COMMUNITY INC	PAOL	l, IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE	
		and the test tray was				
	1	ken to the nurses'				
	ı •	ed for palatability and				
	· ·	th the CDM. The hot				
		, but the milk and				
	l ·	not cold. The CDM				
		res and the milk was				
		and the pudding was 50				
	•	erview with the CDM at				
		ted the pudding was				
	not to be room temperature, but was to be served cold and had been taken out of the refrigerator just prior to					
	service.					
	Review of the Federal Drug Administration 2009 Food Code the					
		noted at 3-501.16:				
		zardous Food. Except				
		tion, cooking, or				
	cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and in (C) or this section, POTENTIALLY HAZARDOUS FOOD(TIME/TEMPERATURE					
	CONTROL FO	R SAFETY FOOD)				
	shall be mainta	ined:				
		C [Celsius] (41 degrees				
	F) or less."					
	3.1-21(a)(2)					
	3.1-21(i)(3)					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011		
155333		B. WING			03/04/2011		
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN47454				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0441 SS=D	and interview, the provide pressure of 3 residents of control practices promote healing in a sample of the observations. If the control pressure ulcer 3/3/11 at 9:43 At the control pressure ulcer 3/3/1	e: of care of the for Resident #113 on A.M., indicated physical perform the treatment. bist [PT] #1 indicated in place. The resident er left side in a bed. incontinent brief rolled ent and visible brown on the brief. s on the right ischium PT#1 indicated the ined up after e current week and ound was 1 cm deep. is round with a 2 cm iness surrounding the ing 5 cm the diameter The woundbed had e that moved around	F04	41	F 441 483.65INFECTION CONTROL, PREVENT SPREALINENSI.Resident #113 was provided peri-care. The dress was then completed. The therapist providing the treatmed was offered education on appropriate infection control techniques.II. The facility review all residents receiving wound of by therapy for potential infection control issues and none were found.III. The systemic change includes that all dressing change will be performed in the reside room to facilitate providing a clean field prior to the dressing change. Therapy and nursing swill be provided education regarding approriate infection control technique during dress changes, with emphasis on providing a clean field prior to dressing change. IV. The Direct of Nursing or her designee will audit a minimum of 3 dressing changes for proper infection control technique weekly for 4 weeks, then a minimum of 3 dressing changes monthly for months, then one time a month for a duration of 12 months monitoring. The Therapy Supervisor will monitor a minimum of 2 dressing changes monthly for ropoper infection control technique. The audit will then occur for a minimum of 2 dressing changes monthly for months. The results of this audit and the control technique of this audit of thi	ing ent wed care on ges nt staff ing the tor 4 h	04/03/2011

AND PLAN OF CORRECTION IDENTIF		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 03/04/2011	
155333		B. WIN			03/04/20	UII	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
PAOLI HEALTH AND LIVING COMMUNITY INC				1	LONGEST ST IN47454		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID (FAC		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1.40	PT #1 indicated department told the resident neshe came down continued to confeces in her brief been sent to the brief the previor continued on wo open wound with incontinent brief area of the would be with the resident with the stage of the would be with the stage of the world be with the world be world be with the world be with the world be with the world be w	If the therapy If the staff upstairs that eded cleaned before in for treatment, but she ime to therapy with ef. The resident had erapy with feces in her is day, also. PT #1 ith the treatment of the ith the feces on the if in the immediate ind. The resident had erapy with feces in her is day, also. PT #1 ith the treatment of the ith the feces on the if in the immediate ind. The resident had erapy with feces in her is day, also. PT #1 ith the treatment of the ith the feces on the if in the immediate ind. The resident had erapy with feces in her is day, also. PT #1 ith the treatment of the ith the feces on the if in the immediate ind. The resident had erapy with ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith the feces in her is day, also. PT #1 ith the treatment of the ith			will be reviewed in the monthly facility Quality Assurance Committee meeting and the frequency and duration of the audits adjusted as needed.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/04/2011	
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY INC			STREET 559 W	ADDRESS, CITY, STATE, ZIP (LONGEST ST I, IN47454	CODE	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION
TAG	The facility's por PRESSURE/N ULCER PREVIMANAGEMEN provided at 3/4 reviewed at 9 A Care and Early Protect skin from perspiration, and "PRESSURE LEWOUND ASSESSED DOCUMENTATION WOUND AND CONTRACTION W	Dlicy "SKIN CARE AND ON-PRESSURE ENTION AND T PROGRAM," //11 at 7:50 A.M. and A.M., indicated "Skin Treatment, Protection, om exudates, and incontinence." JLCER TREATMENT, sment and at When assessing a cumenting findings, owing factors: ss or warmth to touch	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE